DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11054A (Rev. 07/04)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / ENTERAL NUTRITION PRODUCT ATTACHMENT (PA/ENPA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information in this form and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Providers should refer to their service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Enteral Nutrition Product Attachment (PA/ENPA) to the Prior Authorization Request Form (PA/RF) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth — Recipient
Enter the recipient's date of birth.

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — TYPE OF REQUEST

Element 4
Indicate the start date requested for PA or the date the prescription was filled.

Element 5
Check the appropriate box to indicate if this product has been requested previously.

SECTION III — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

Element 6 — Product Name
Enter the product name.

Element 7 — Quantity Ordered
Enter the quantity that was ordered.

Element 8 — Date Order Issued
Enter the date the order was issued.

Element 9 — Directions for Use of Product
Enter the directions for use of the product.

Element 10 — Daily Dose
Enter the daily dose.

Element 11 — Refills
Enter the amount of refills.

Element 12 — Name — Prescriber
Enter the name of the prescriber.

Element 13 — Drug Enforcement Administration Number
Enter the Drug Enforcement Administration (DEA) number. If the provider is unable to obtain a prescriber's current DEA number after a reasonable effort, the provider may use the appropriate default DEA number:

- XX5555555 — Prescriber's DEA number cannot be obtained.
- XX9999991 — Prescriber does not have a DEA number.

Default DEA numbers may be indicated for prescriptions for enteral nutrition products; however, default DEA numbers must *not* be used for prescriptions for controlled substances.

SECTION IV — CLINICAL INFORMATION
Include diagnostic, as well as clinical, information explaining the need for the product requested.

Element 14
List the recipient's condition the product is intended to treat. Include the expected length of need. If requesting a renewal or continuation of a previous PA approval, indicate any changes to the clinical condition, progress, or known results to date. Attach another sheet if additional room is needed.

Element 15
Indicate source of clinical information.

Element 16
Indicate use of the product requested.

Element 17
Indicate dosage of the product requested.

SECTION V — ADDITIONAL INFORMATION REQUIRED FOR ENTERAL NUTRITION SUPPLEMENTS

Element 18
Enter the percentile (children only) and the height. If this is other than the first request, please include the first measurements from the initial request as well as the current information.

Element 19
Enter the percentile (children only) and the weight. If this is other than the first request, please include the first measurements from the initial request as well as the current information.

Element 20
Enter the amount of weight loss, if any, and within what specific time span the weight was lost.

Element 21
Check all that apply.

Element 22 — Signature — Pharmacist or Dispensing Physician
The pharmacist/dispenser must review this information and sign this form.

Element 23 — Date Signed
Enter the month, day, and year the PA/ENPA was signed (in MM/DD/YYYY format).

Element 24
Check the appropriate box indicating how the provider would like to be notified of an approved or denied PA request. Be sure to indicate a fax or telephone number if selecting either of these options.